POMONA UNIFIED SCHOOL DISTRICT
HEALTH SERVICES & PROGRAMS
Parent/Guardian Consent, Waiver and Release from Liability Regarding Administration of Inhaler and/or Auto-Injectable Epinephrine Medication by Student

I am the parent, legal guardian or foster parent of _____

Date of Birth: _____ **Grade:** _____ **School:** _____

Address: _____ **Phone:** _____

_____

I hereby request and authorize the school to permit my child to carry and self-administer prescription inhaler and/or auto-injectable epinephrine medication during school hours. I hereby also give my consent for the school nurse to communicate directly with our physician as may be necessary regarding any concerns or questions related to the administration of the medication(s).

I understand it is my responsibility to send my child's medication(s) to school in the original pharmacy container including my child's name and the doctor's instructions.

I will notify the school nurse or principal immediately if there is a change in my child's medication schedule or if the prescribing physician is no longer providing health care for my child.

THE UNDERSIGNED DOES HEREBY RELEASE AND DISCHARGE THE POMONA UNIFIED SCHOOL DISTRICT INCLUDING, BUT NOT LIMITED TO IT'S OFFICERS, AGENTS AND EMPLOYEES, FROM ANY AND ALL CLAIMS FOR ANY LOSS, DAMAGE, INJURY OR LIABILITY OF ANY KIND TO MY CHILD OR ANY OTHER PERSON CAUSED OR ARISING FROM THE ACTS, OMISSIONS OR NEGLIGENCE OF THE DISTRICT, IT'S OFFICERS, EMPLOYEES OR AGENTS RELATED TO THE SELF-ADMINISTRATION OF AN INHALER AND/OR AUTO-INJECTABLE EPINEPHRINE MEDICATION BY MY CHILD AS A RESULT OF THIS AUTHORIZATION.

Signature of Parent, Legal Guardian or Foster Parent: _____ Date: _____

Print Name of Parent, Legal Guardian or Foster Parent: _____

Telephone number: (daytime) _____ Cell number: _____

ONE FORM PER MEDICATION

Please complete and return this form to the school nurse

Revised 7/2013